Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDI-PLUS PHARMACY
PO BOX 546
BARKER TX 77413

Respondent Name

TEXAS MUTUAL INSURANCE CO.

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-4389-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The Requestor did not submit a Position Summary.

Amount in Dispute: $498.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Using the best information available to it, Texas Mutual has established an educated estimate for the pharmacy's U&C charges to customers outside the workers' compensation system and paid Medi-Plus Pharmacy those amounts because such amounts were lower than the formula amount in Rule 134.503(a). Texas Mutual recognizes that the pharmacy's actual U&C charge may be different (higher or lower) than Texas Mutual's estimated value. However, Medi-Plus Pharmacy has never provided any information to substantiate that the amount it charged Texas Mutual was in fact the U&C price for the drugs at issue despite Texas Mutual's best evidence that it was not."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
April 8, 2010 – July 22, 2010	SUBOXONE	$498.24	$0.00 MDR Waived

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

Issues

1. Were all the services in dispute filed in the form and manner prescribed by the division?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c) states, in pertinent part, that "[a]requestor shall timely file with the Division's MDR Section or waive the right to MDR." Rule 133.307(c)(1)(A) explains that "[a]request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." This medical fee dispute was filed on July 28, 2011. The dates of service range from April 8, 2010 through July 22, 2010. The requests for medical fee dispute resolution for the dates of service from April 8, 2010 through July 22, 2010 were not filed within one year and do not involve issues identified in Rule 133.307(c)(1)(B); therefore the requests for those dates of service do not meet the requirements of 28 Texas Administrative Code §133.307(c)(1)(A). The division concludes that the requestor has waived the right to medical fee dispute resolution for the April 8, 2010 through July 22, 2010 services.

Conclusion

For the reasons stated above, the Division finds that no additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 6, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), **including a certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.